Epidiolex (cannabidiol) for Dravet Syndrome (DS)

EXCEPTION DRUG STATUS (EDS) REQUEST FORM

Fax: (204) 942-2030 or 1-877-208-3588

Prescriber Name:	**Fax Number:**
Prescriber Address:	**Phone Number:**
	Prescriber License Number (NOT Billing Number):

Patient First Name:	**PHIN:**	**MHSC:**
Patient Last Name:	**Patient's Date of Birth:**	

◯ **Initial Request** ◯ **Renewal Request**

Medication: Epidiolex (cannabidiol)	**Strength and Regimen:**	**Duration:**

Exception Drug Status (EDS) approval is only granted upon demonstration that the patient meets the coverage criteria of the EDS listing. Please provide the following details about how this patient meets the specific criteria for coverage. Manitoba Health may request additional documentation to support this EDS request.

For INITIAL Requests:

Diagnosis/Indication:	◯ For adjunctive treatment of seizures associated with Dravet Syndrome (DS)
	◯ Other: _____

Please select YES or NO to the following statements.

The patient is 2 years of age or older.	◯ YES	◯ NO
The patient is under the care of a specialist with experience in the diagnosis and management of DS.	◯ YES	◯ NO
The patient has inadequate seizure control despite the **current** use of 2 or more anti-seizure medications.	◯ YES	◯ NO
The patient has at least 4 convulsive seizures per month. • Number of convulsive seizures experienced in the past month: _____	◯ YES	◯ NO
Will the patient be using cannabis products (recreational or medicinal) or other cannabinoid-based medications concurrently with Epidiolex?	◯ YES	◯ NO

Please provide the following details for the medications tried (as checked off above):

Anti-seizure Medications Tried	*Dosing Regimen Used*	*Start Date*	*End Date*	*Response to Trial*
				☐ Ineffective ☐ Intolerance (specify): ☐ Contraindication (specify): ☐ Other (specify):
				☐ Ineffective ☐ Intolerance (specify): ☐ Contraindication (specify): ☐ Other (specify):
				☐ Ineffective ☐ Intolerance (specify): ☐ Contraindication (specify): ☐ Other (specify):

For RENEWAL Requests:		
Please select YES or NO to the following statements.		
The patient continues to be under the care of a physician with experience in the diagnosis and management of DS.	◯ YES	◯ NO
Is the patient concurrently using cannabis products (recreational or medicinal) or other cannabinoid-based medications?	◯ YES	◯ NO
Please provide proof of a beneficial clinical effect (as demonstrated by examples below):		
Please provide the number of convulsive seizures experienced by the patient in the past month: _____		
If applicable, please provide any other relevant information to support a beneficial clinical effect such as:		
Changes in sleep disruption and/or daytime sleepiness:		
Changes in the use of rescue medication:		
Changes in the number of inpatient hospitalizations due to seizure activity:		
Other relevant information:		

Prescriber Signature and Date:	
☐ **I have discussed with the patient that the purpose of releasing their information to Manitoba Health, Seniors and Long-Term Care is to obtain Exception Drug Status for prescription coverage.**	
Date:	Prescriber Signature: